est treatment-specific costs. Total costs for the surveillance/compression therapy cohort, although lower, were comparable to those that received invasive therapies.

PCV46

HEALTH CARE RESOURCE UTILIZATION AND COSTS IN A SAMPLE OF REAL-WORLD PATIENTS WITH SEVERE HYPERTRIGLYCERIDEMIA

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OBJECTIVES: Patients with severe hypertriglyceridemia often experience a variety of symptoms, including acute pancreatitis. Little is known about the health care cost burden among such patients. This study investigated the real-world health care utilization and costs of hypertriglyceridemia in a large commercially insured US population. **METHODS:** A retrospective observational claims study was conducted among adult patients identified from the HealthCore Integrated Research Database[SM]. Patients with TG>500 mg/dL between 1/1/2007 and 4/30/2013 were placed into three mutually exclusive cohorts based on first available TG measurement (index date). Patients were required to have ≥12 months of eligibility pre-(baseline) and post-index date (follow-up). Baseline and follow-up annual health care resource utilization and costs were assessed descriptively using ICD-9-CM codes for identification of relevant dyslipidemia claims. Costs associated with an acute pancreatitis episode were estimated using GLM. **RESULTS:** We identified N=1,964 patients with TG≥1500 (Cohort A), N=7,432 with 750≤TG<1500 (Cohort B), and N=17,500 with 500<TG<750 mg/dL (Cohort C). Across all cohorts, patients were young (mean age 46-48) and mostly males (75-80%). At baseline, health care utilization and costs were similar between Cohorts B and C, but higher in Cohort A (mean all-cause medical and pharmacy costs of $8,850/patient). At follow-up, the number of patients with dyslipidemia-related office and other outpatient visits, as well as pharmacy dispensing, approximately doubled in all three cohorts, as did related costs. Mean all-cause costs/patient in Cohort A at follow-up were $12,642, of which $3,730 were dyslipidemia-related. Presence of an acute pancreatitis episode was associated with a >300% increase in total all-cause costs in Cohort A. **CONCLUSIONS:** In this sample of commercially insured patients, results suggest that health care utilization and costs scale with the level of TG elevation with patients having more severe hypertriglyceridemia requiring more medical interaction and pharmacotherapy. Treating severe hypertriglyceridemia and preventing acute pancreatitis may result in substantial cost savings.

PCV47

COST OF ILLNESS OF WIDE PULSE PRESSURE IN JAPAN

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OBJECTIVES: The study aimed to estimate the health care resources used and costs among hypertensive patients with wide pulse pressure (wWPP) and without (woWPP) in Japan. **METHODS:** A retrospective chart review was conducted in 15 physicians' offices distributed all over Japan. Two historic cohorts of patients were included with hypertension for ›3 years, ›20 years old, and two consecutive readings showing wWPP (pulse pressure ≥ 60 mmHg) or woWPP 3 to 5 years before inclusion. Patients were followed-up for three years. Variables retrieved were: sociodemographic data and comorbidities, variables related with hypertension, including target organ damage, hypertension management and the health care resources used for the last 12 months of follow-up. The study was approved by an IRB. Direct health care costs were estimated based on unit cost on annual basis from payer perspective. A regression model was performed for cost data. Statistical significance was set at p<0.05. **RESULTS:** Overall 276 patients participated; 150 wWPP vs 126 woWPP, 42.0% vs 63.5% males (p=0.0004), mean (SD) age 69.8 (9.9) vs 58.8 (9.9) years (p<0.0001). Mean (SD) health care resources cost of wWPP was ¥88,829.01 (USD 39,061.60), being 59.5% related to anti-hypertensive pharmacological treatment and 39.7% to outpatient visits. Mean (SD) cost of woWPP was ¥75,092.16 (31,899.12). Higher costs for wWPP patients were due to higher cost of pharmacological treatment (p=0.02) and higher costs of outpatient visits (p=0.002). In regression model, diagnosis of type-2 diabetes mellitus and target organ damage (cerebral hemorrhage/infarction, left ventricular hypertrophy, proteinuria) were related to a mean increase of total cost of ¥11,271 (p=0.0114) and ¥22,589 (p=0.0010), respectively. **CONCLUSIONS:** Patients wWPP were more frequently females and older than woWPP, and health care resources used were greater, mainly due to higher expenses on treatments and outpatient visits. Type-2 diabetes mellitus and target organ damage were associated to the cost increase.

PCV48

MANAGEMENT OF CEREBROVASCULAR EVENTS IN TERTIARY HOSPITALS IN TURKEY AND EFFECTS OF MALNUTRITION ON THE MANAGEMENT: A COST OF ILLNESS ANALYSIS

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OBJECTIVES: Cerebrovascular events (CVE) cause major health problems and significant financial burden. Concomitant malnutrition may deteriorate prognosis of CVE and increase management costs. The study aims to describe daily practice for CVE management in patients with/without malnutrition in terms of diagnosis, treatment and follow-up. In this abstract, we calculate direct medical costs related to CVE in patients with/without malnutrition from the perspective of the local reimbursement authority in Turkey (SSI). **METHODS:** Acute CVE patients are generally referred to tertiary centers in Turkey, therefore neurology specialists experienced on CVE management from 8 tertiary-centers filled out a questionnaire including questions about diagnosis, treatment and follow-up of CVE. Answers were combined and summarized by using mean and standard error(SE). Direct medical costs were calculated by using package price and drug price lists of SSI in December 2013. Time horizon of analysis was 1 year. Monetary results were converted by using 2.1 USD/TL exchange rate. **RESULTS:** Mean(SE) 76.4(7.5)% of patients were hospitalized at first admittance (mean(SE) 39.2(7.7)% were to intensive-care unit). Mean(SE) mortality rate of the first admittance was 10.3(2.9)%. The first admittance of patients with/without malnutrition cost mean(SE) $3062(513) and $1958(372), respectively. During 1-year follow-up period; mean(SE) 93.8(15.4)% and 43.3(3.7)% of patients with/without malnutrition were expected to experience at least 1 complication, respectively. Routine procedures and complications during 1-year follow-up cost mean(SE) $2140(390) and $1660(340) for patients with/without malnutrition, respectively. Overall mean(SE) 1-year cost of patient with/without malnutrition $5201(740) and $3618(614) respectively. Of total amounts, oral nutrition supplements (ONS) cost mean(SE) $868(335) and $501(281) whereas all others cost mean(SE) $4334(807) and $3117(636), respectively. **CONCLUSIONS:** The results of analysis revealed that management of CVE and its complications have a relatively high burden on the Turkish health reimbursement system. Moreover, malnutrition increases overall costs and, investment in ONS may decrease overall CVE management cost.

PCV49

LONG TERM HEALTH CARE COSTS FOR PATIENTS WITH STABLE CORONARY ARTERY DISEASE (CAD) AFTER MYOCARDIAL INFARCTION IN THE UNITED STATES

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BACKGROUND: The health care cost associated with myocardial infarction (MI) is highest the first year after an MI. However health care costs may continue to be high post MI for patients with stable CAD and at least one additional atherothrombotic risk factor. **OBJECTIVES:** To evaluate long term cardiovascular (CV) related and all cause health care costs in patients with stable CAD after MI and at least one additional atherothrombotic risk factors, resembling patients of the PEGASUS trial (NCT 01225562). **METHODS:** Health plan members, ≥ 50 years with no prior stroke, hospitalized with an MI diagnosis (index event) and MI free for 12 months (stable CAD) were identified from the HealthCore Integrated Research Environment, between 01/2007 and 11/2011. Rates of MI and stroke hospitalizations during a 2-year follow-up were calculated. CV related and all cause health care costs were evaluated per patient. Hospitalization rates and health care costs were only evaluated in patients <65 years due to data and population limitations in the database. **RESULTS:** Of 13 492 stable CAD patients identified, 5357 met the PEGASUS inclusion criteria with at least one additional atherothrombotic risk factor (≥1 prior MI, diabetes or chronic non end-stage renal disease). The MI and stroke related hospitalization rates for patients with stable CAD and fulfilling the PEGASUS criteria at 2 years post index event, were 7.7% and 2.5%, respectively. The CV related and all cause health care cost per patient year during the follow up period were $15 247 and $26 073 for patients with and $7 521 and $13 566 for patients without at least one additional atherothrombotic risk factor. **CONCLUSIONS:** The economic burden post MI for patients below 65 years with stable CAD and at least one additional atherothrombotic risk factor in a US managed care population is substantial several years following an MI.

PCV50

THE ECONOMIC BURDEN OF POSTOPERATIVE THROMBOEMBOLISM OF PULMONARY ARTERY

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OBJECTIVES: the costs of treatment of patients with pulmonary embolism (PE), which has developed after large surgery and includes the cost of hospital stay, treatment, the cost of medicines, non-drug technologies and rehabilitation. In most studies, cost estimation is performed using a survey of experts and modeling. The objectives of the study were to conduct a cost analysis of patients with PE, which has showed after the operations in "real" practice. **METHODS:** A retrospective analysis. When analyzing the costs only direct costs were calculated. Total costs were counted by adding costs of medicines, transaction costs, costs of laboratory and instrumental methods of research, medical services, medical staff, costs of hospital stay. **RESULTS:** 13 patients after various general surgeries. The average age was 73.42±3.26 years. All patients had higher risk of venous thromboembolism. Postoperatively, patients received thromboprophylaxis. PE has developed by an average on 12thday after surgery, and in 69.23% of cases the development of PE resulted in death. In 92.3% the source of PE was deep vein thrombosis of the lower limbs. The costs of 13 patients with PE were 102 174 USD, the average - 7860 USD for 1 patient (minimum costs - 230 USD, maximum - 26 799 USD). The highest costs were drugs – 33 136 USD (32.43%), services of medical staff – 46 483 USD (45.5%), laboratory and instrumental methods of investigation – 40 601 USD (10.8%), hospital stay – 5659 USD (9.14%), surgeries – 2811 USD (2.75%). **CONCLUSIONS:** the development of pulmonary embolism after surgical intervention is not only clinical, but also an economic problem. PE develops in average on 12 days after surgery, in 69.23% ends in death. The costs of 1 patients in average is 7860 USD. The highest costs were for medicines and staff services due to the high cost and frequency of use.

PCV51

MEDICAL INNOVATION AND THE CHANGING HEALTH AND HEALTH CARE COSTS OF OBESITY

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OBJECTIVES: To measure the impact of medical innovation on the health and health care costs of obesity, using statins as a case study. **METHODS:** Life trajectories and